Appendix 20
SAMPLE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF)

DO NOT DETACH TOP 2 FORMS - Reminder: ENCLOSE PA/DA with PA/DRF

MAIL TO
EDS
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PA/DRF
WISCONSIN MEDICAID DENTAL
PRIOR AUTHORIZATION REQUEST FORM
(DO NOT WRITE IN THIS SPACE)
A.T. #
P.A. # 1271692

ICN #

1. PROCESSING TYPE (MARK ONE)
DENTAL - 124 ☐
ORTHO - 125 ☐

2. RECIPIENT'S MEDICAID ID NUMBER

3. RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)
(Write name exactly as it appears on the Medicaid ID card)

4. RECIPIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

5. DATE OF BIRTH __/__/__

6. SEX M ☐ F ☐

7. BILLING PROVIDER NO.

8. PERFORMING PROVIDER NO. (if different)

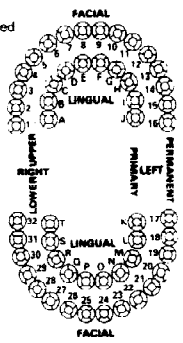
9. BILLING PROVIDER NAME, ADDRESS, ZIP CODE
(If stamped, please stamp every copy)

10. PROVIDER TELEPHONE NO.

11. INDICATE IF THE SERVICE WILL BE PERFORMED IN:
- INPATIENT HOSPITAL (POS 1) ☐
- OUTPATIENT HOSPITAL (POS 2) ☐
- AMBULATORY SURG. CENTER (POS 8) ☐
- DENTAL OFFICE (POS 3) ☐

12. TOOTH #	13. PROCEDURE CODE	14. QUAN.	15. DESCRIPTION	16. FEE	
			18. TOTAL FEES		

17.
- Circle periodontal case type if applicable to the service requested
  I II III IV V
- Cross out missing teeth
- Circle teeth to be extracted



Staple X-Ray Envelope Here

NUMBER OF X-RAYS _____

TYPE OF X-RAYS _____

An approved prior authorization does not guarantee payment. Prior authorized services: 1) are subject to the applicable terms of reimbursement issued by the Department; 2) must be provided consistent with a prior authorization, as approved or modified by the Department or its fiscal agent; and 3) are reimbursable only if and to the extent the provisions of s. HFS 107.02(3), Wis. Admin. Code, are met. Payment will not be made for services initiated prior to the approval or after the authorization expiration date. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, reimbursement will be allowed only if the service is not covered by the HMO and all other program requirements are met.

19. RECIPIENT/GUARDIAN SIGNATURE (*Optional*)
Date

20. PERFORMING PROVIDER SIGNATURE
(If stamped, please stamp every copy)
Date

MEDICAID CONSULTANT USE ONLY - DO NOT WRITE IN THIS SPACE

AUTHORIZATION: PROCEDURE(S) AUTHORIZED: QUANTITY AUTHORIZED:

☐ APPROVED GRANT DATE EXPIRATION DATE

☐ MODIFIED REASON _____

☐ DENIED REASON _____

☐ RETURN REASON _____

DATE MEDICAID CONSULTANT/ANALYST SIGNATURE

Appendix 20
SAMPLE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF)
(continued)

MAIL TO:
EDS
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PA/DRF
WISCONSIN MEDICAID DENTAL PRIOR AUTHORIZATION REQUEST FORM
(DO NOT WRITE IN THIS SPACE)
A.T. #
P.A. # 1271692

ICN #

1. PROCESSING TYPE (MARK ONE)
DENTAL - 124 ☐
ORTHO - 125 ☐

2. RECIPIENT'S MEDICAID ID NUMBER

3. RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)
(Write name exactly as it appears on the Medicaid ID card)

4. RECIPIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

5. DATE OF BIRTH ___/___/___

6. SEX M ☐ F ☐

7. BILLING PROVIDER NO.

8. PERFORMING PROVIDER NO. (If different)

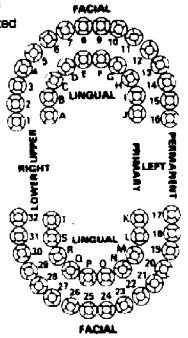
9. BILLING PROVIDER NAME, ADDRESS, ZIP CODE
(If stamped, please stamp every copy)

10. PROVIDER TELEPHONE NO.

11. INDICATE IF THE SERVICE WILL BE PERFORMED IN:
- INPATIENT HOSPITAL (POS 1) ☐
- OUTPATIENT HOSPITAL (POS 2) ☐
- AMBULATORY SURG. CENTER (POS 8) ☐
- DENTAL OFFICE (POS 3) ☐

12. TOOTH #	13. PROCEDURE CODE	14. QUAN.	15. DESCRIPTION	16. FEE	
			18. TOTAL FEES		

17.
- Circle periodontal case type if applicable to the service requested
  I II III IV V
- Cross out missing teeth
- Circle teeth to be extracted



Staple X-Ray Envelope Here

NUMBER OF X-RAYS _____

TYPE OF X-RAYS _____

An approved prior authorization does not guarantee payment. Prior authorized services: 1) are subject to the applicable terms of reimbursement issued by the Department; 2) must be provided consistent with a prior authorization, as approved or modified by the Department or its fiscal agent; and 3) are reimbursable only if and to the extent the provisions of s. HFS 107.02(3), Wis. Admin. Code, are met. Payment will not be made for services initiated prior to the approval or after the authorization expiration date. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, reimbursement will be allowed only if the service is not covered by the HMO and all other program requirements are met.

19. RECIPIENT/GUARDIAN SIGNATURE (*Optional*)
Date

20. PERFORMING PROVIDER SIGNATURE
(If stamped, please stamp every copy)
Date

PROVIDER CHECKLIST
REQUESTS FOR PERIODONTICS, ENDODONTICS, AND SERVICES REQUIRING ENCLOSURES

HAVE YOU ENCLOSED?

X-rays for any of the following:
- Space maintainer ____
- Resin window SSC/resin crown ____
- Endodontics ____
- Partials and fixed prosthetics ____
- Surgical exposure of unerupted tooth ____
- Removal of foreign body ____

Periodontal charting required for any of the following procedures:
- Periodontal scaling and root planing ____
- Full mouth debridement ____
- Periodontal maintenance ____
- Partials *(for perio case types II, III, IV, and V only)* ____
- Fixed prosthodontics (abutment teeth) ____

HealthCheck referral for any of the following:
- Osteoplasty/Orthognathic surgery ____
- Surgical exposure of unerupted tooth ____
- Frenulectomy ____
- Orthodontics ____

Statement on speech impediment for:
- Palatal lift ____

TMJ surgery requirements - Enclose each of the following:
- Second surgical opinion ____
- Document non-surgical treatment ____
- Operative and post-operative plan of care ____
- X-ray report ____

When requesting upgraded crowns and upgraded partial dentures, the form "Provision of Upgraded Partial Denture and Crowns to Medicaid Recipients" in the Dental Provider Handbook (Part B) must be completed, signed, and attached to this form.

PROVIDER COPY - RETAIN FOR YOUR RECORDS
DISCARD UPON RECEIPT OF PROCESSED PRIOR AUTHORIZATION REQUEST

Appendix 21
PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF) COMPLETION GUIDELINES

The Prior Authorization Dental Request Form (PA/DRF) is to be used by all dentists requesting prior authorization (PA) for dental or orthodontic services.

All dentists requesting PA need to complete the following:

Service requested	Pages to complete
Additional dental visits or cleanings	PA/DRF and PA/DA page 1
Orthodontia	PA/DRF and PA/DA page 1
Endodontics, Periodontics, Partial dentures	PA/DRF and PA/DA pages 1 and 2
Partials, Dentures	PA/DRF and PA/DA pages 1, 2, and 3

Photocopy the necessary pages of the PA/DA form from Appendix 22 of this handbook.

Submit the PA/DRF and the appropriate page(s) of the PA/DA to the following address:

Prior Authorization Unit
EDS
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/DRF COMPLETION INSTRUCTIONS

BOX #	DESCRIPTION	INSTRUCTIONS
1	PROCESSING TYPE	Mark the appropriate box.
2	RECIPIENT'S MEDICAID ID NUMBER	Enter the recipient's 10-digit Medicaid number exactly as it appears on the Medicaid identification card.
3	RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)	Enter the recipient's name exactly as it appears on the Medicaid identification card.
4	RECIPIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	Enter the address of the recipient's place of residence. The street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, enter the name of the nursing home or facility.
5	RECIPIENT'S DATE OF BIRTH	Enter the recipient's date of birth in MM/DD/YY format.
6	RECIPIENT'S SEX	Specify male or female.
7	BILLING PROVIDER NUMBER	Enter the billing provider's 8-digit Medicaid provider number. Use the billing number you will use on Medicaid claims.
8	PERFORMING PROVIDER NUMBER (if different)	**The performing provider is the dentist who will actually provide the service. Complete this section if the performing provider is different from the billing provider.** Enter the performing provider's 8-digit Medicaid provider number.
9	BILLING PROVIDER'S ADDRESS (if stamped, please stamp every copy.)	Enter the name and the address of the billing provider. The street, city, state, and zip code must be included. If you use a stamp for the name and address, please stamp all three copies of the PA/DRF form. No other information should be included in this section because it also serves as a return mailing label.

Appendix 21
PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF) COMPLETION GUIDELINES
(continued)

BOX #	DESCRIPTION	INSTRUCTIONS
10	PROVIDER TELEPHONE NUMBER	Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the provider.
11	INDICATE IF THE SERVICE WILL BE PERFORMED IN:	Mark the proper place of service code which desginates where the requested service/procedure will be provided. Do not mark any of these boxes if the requested service will be performed in a location other than inpatient hospital, outpatient hospital, ambulatory surgery center, or dental office.
12	TOOTH NUMBER (*or letter*)	Using the numbers and letters on the Tooth Chart in box 17, identify the tooth number or letter for the service requested.
13	PROCEDURE CODE	Enter the appropriate procedure code for each service/procedure requested on each line.
14	QUANTITY (*of service requested*)	Dentists: Enter the number of services requested for each service/procedure requested. If requesting five years of prophylaxes or fluoride services for permanently disabled recipients, with four services requested each year, request 20 units of service. Orthodontists: Enter a quantity of "1" in this box.
15	DESCRIPTION (*of service*)	Enter a written description corresponding to the appropriate procedure code for each service/procedure.
16	FEE	Enter your usual and customary charge for each service/procedure requested (the amount charged to non-Medicaid patients).
17	PERIODONTAL CASE TYPE, TOOTH CHART, & X-RAYS	For Partials, Endodontics, and Periodontics, circle the periodontal case type. On the diagram, cross out ("X") missing teeth (including extractions). Circle teeth to be extracted only when requesting endodontic or partial denture services. Indicate the number and type of x-rays submitted with this prior authorization request. (We request this information to ensure we receive all the x-rays sent with the PA/DRF.)
18	TOTAL FEES	Enter the anticipated total charge for this request.
19	RECIPIENT/GUARDIAN SIGNATURE (*Optional*)	The recipient or the recipient's guardian can sign and date the prior authorization request so they are informed about the request.
20	PROVIDER SIGNATURE (*If stamped, please stamp every copy.*)	The provider must sign and date the prior authorization request. If you use a stamp for the provider signature, please stamp all three copies of the PA/DRF form.

DETACH AND KEEP THE BOTTOM COPY OF THE PA/DRF.
LEAVE THE TOP TWO FORMS ATTACHED.

Keep the bottom copy of the PA/DRF. You can discard this copy once you receive the processed prior authorization request.

PROVIDER CHECKLIST: The bottom copy features a Provider Checklist to assist with requests for periodontics, endodontics, and services requiring enclosures. For additional information, consult Appendix 24 of this handbook.

Appendix 22
SAMPLE PRIOR AUTHORIZATION DENTAL ATTACHMENT REQUEST FORM (PA/DA)

DENTAL AND ORTHODONTICS PRIOR AUTHORIZATION (PA/DA) FORM
(Attach to PA/DRF form)

WRITE IN P.A. # *(preprinted in red ink on PA/DRF form)*	RECIPIENT'S MEDICAID ID #	BILLING PROVIDER #	PERFORMING PROVIDER # *(If different)*

PA/DA PAGE 1

COMPLETE THIS PAGE FOR ALL DENTAL AND ORTHODONTIC PRIOR AUTHORIZATION REQUESTS

Please answer all questions on this page. If necessary, attach additional pages for your responses.

1. **Complete for all dental services.** Dental diagnosis / Description of present condition:

2. **Complete for Orthodontics .** Type of malocclusion:

3. **Complete for all dental services.** Dental indications, dental history, or medical need pertinent to treatment requested:

4. **Complete for all dental services.** Specific treatment plan:

5. **Complete for Orthodontics.** Anticipated number of monthly adjustments:

6. **Complete for all dental services.** Overall treatment prognosis (circle one)

EXCELLENT	GOOD	FAIR	POOR

If POOR, please explain the reason for the requested treatment.

7. **Complete for all dental services.** Indicate if the recipient is physically, psychologically, otherwise indefinitely disabled, or has a medical condition that impacts the treatment requested.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

Appendix 22
SAMPLE PRIOR AUTHORIZATION DENTAL ATTACHMENT REQUEST FORM (PA/DA)
(continued)

PA/DA PAGE 2

COMPLETE THIS PAGE FOR:

ENDODONTICS (Questions 1, 2, 3, 4, 5, 6 and 8)

PERIODONTICS (Questions 1, 2, 3 and 7)

PARTIAL DENTURES (Questions 1, 2, 3, 8 and 9 – also complete Page 3)

If necessary, attach additional pages for your responses.

1. **Complete for Endodontics, Periodontics, or Partial Dentures.** Condition of caries control:
   - a. Restorative treatment plan has not been started. ☐
   - b. Restorative treatment plan is in progress. ☐
   - c. Restorative treatment plan has been completed. ☐

2. **Complete for Endodontics, Periodontics, or Partial Dentures.** Oral hygiene status (circle one):

EXCELLENT	GOOD	FAIR	POOR

3. **Complete for Endodontics, Periodontics, or Partial Dentures.** Recipient attendance (circle one):

EXCELLENT	GOOD	FAIR	POOR	NEW PATIENT

4. **Complete for Endodontics.** Have recipient provide reasons and estimated dates for any extractions within the past three years.

5. **Complete for Endodontics.** Is the requested tooth an abutment for a partial/bridge?

   Yes ☐ No ☐

   If yes, indicate age and condition of partial/bridge.

6. **Complete for Endodontics.** For endodontic treatment, indicate if the tooth can be restored.

   ☐ I am able to restore the tooth using Medicaid-covered services.

Medicaid does not cover post and core or a permanent crown. If restoration requires the use of services not covered by Medicaid, please indicate whether the recipient has agreed to pay for services necessary to complete the restoration which are not covered by Medicaid.	Yes, the recipient has agreed to pay for restorative services not covered by Medicaid. ☐ No, the recipient has not agreed to pay for restorative services not covered by Medicaid. ☐

7. **Complete for Periodontics.** Describe a comprehensive periodontal treatment plan, including pre- and post-operative care.

8. **Complete for Endodontics or Partial Dentures.** Are all remaining teeth decay-free, properly restored, and periodontally healthy to ensure a good five-year prognosis?

   Yes ☐ No ☐

   If no, please explain restorations in progress.

9. **Complete for Partial Dentures.** If all necessary extractions have not been completed, please explain why.

Appendix 22
SAMPLE PRIOR AUTHORIZATION DENTAL ATTACHMENT REQUEST FORM (PA/DA)
(continued)

DENTAL AND ORTHODONTICS PRIOR AUTHORIZATION (PA/DA) FORM
(Attach to PA/DRF form)

WRITE IN P.A. # *(preprinted in red ink on PA/DRF form)*	RECIPIENT'S MEDICAID ID #	BILLING PROVIDER #	PERFORMING PROVIDER # *(if different)*

PA/DA PAGE 3

COMPLETE THIS PAGE FOR:
PARTIALS
DENTURES

Respond to all applicable questions if the recipient has and/or is requesting a removable complete or partial denture. Mark appropriate boxes.

If necessary, attach additional pages for your responses.

1. Does the recipient have a partial or denture(s)?

   Yes ☐ No ☐

   If yes, *please indicate:*

   Full ☐ Max. ☐ Mand. ☐

   Partial ☐ Max. ☐ Mand. ☐

2. Does the recipient wear his/her partial or denture(s)?

   Yes ☐ No ☐

   If no, answer question 3.

   If yes, *please indicate:*

   Max. ☐ Mand. ☐

3. If the recipient is no longer wearing the partial or denture(s), when did the recipient stop wearing it?

   Max _____ Mand _____

   Reason why the recipient stopped wearing existing partial / denture(s):

4. How old is the existing partial or denture(s)?

   Max _____ Mand _____

   Reason why the partial or denture(s) cannot be relined:

5. If the recipient is edentulous, how long edentulous?

   Max _____ Mand _____

Policy on Lost, Stolen or Severely Damaged Dentures	Documentation for Lost, Stolen or Severely Damaged Dentures
Wisconsin Medicaid does not routinely replace lost, severely damaged, or stolen prostheses. These prior authorization requests are only approved when: • The recipient has exercised reasonable care in maintaining the denture; • The prosthesis was being used up to the time of loss or theft; • The loss or theft is *not* a repeatedly occurring event; • A reasonable explanation is given for the loss or theft of the prosthesis; and • A reasonable plan to prevent future loss is outlined by the recipient or the facility where the recipient lives.	The dentist must attach documentation of the loss of dentures from the appropriate source. Documentation may include: • Police report, accident report, or fire report; • Hospital, nursing home, or group home/community based residential facility administrator statement on the loss; • Recipient statement on the loss.

See Wisconsin Medicaid Provider Handbook, Part B (Dental) for more information.

Appendix 23
PRIOR AUTHORIZATION DENTAL ATTACHMENT REQUEST FORM (PA/DA) COMPLETION GUIDELINES

When completing prior authorization (PA) requests, thoroughly answer all appropriate questions. Provide enough key information for Wisconsin Medicaid dental consultants to make a reasonable judgement about the case. This will decrease the number of resubmissions and prevent denials due to inadequate information.

All dentists requesting PA need to complete the following:

Service requested	Pages to complete
Additional dental visits or cleanings	PA/DRF and PA/DA page 1
Orthodontia	PA/DRF and PA/DA page 1
Endodontics, Periodontics, Partial dentures	PA/DRF and PA/DA pages 1 and 2
Partials, Dentures	PA/DRF and PA/DA pages 1, 2, and 3

Attach the appropriate pages of the completed PA/DA form to the Prior Authorization Dental Request Form (PA/DRF) and submit to the following address:

Prior Authorization Unit
EDS
Suite 88
6406 Bridge Road
Madison WI 53784-0088

HEADER COMPLETION INSTRUCTIONS – ALL PA/DA PAGES

The numeric information in the boxes at the top of each page of the PA/DA form must be completed. This information ensures accurate tracking of the PA/DA form with the PA/DRF form through the PA review process. This form will be returned to you for completion if this numeric information is not provided at the top of each page of the PA/DA form you submit.

DESCRIPTION	INSTRUCTIONS
WRITE IN PA #	Write in the red, preprinted number stamped at the top of the PA/DRF form.
RECIPIENT'S MEDICAID ID #	Enter the recipient's 10-digit Medicaid number exactly as it appears on the Medicaid identification card.
BILLING PROVIDER #	Enter the billing provider's 8-digit Medicaid provider number.
PERFORMING PROVIDER # *(if different)*	The performing provider is the dentist who will actually provide the service. You only need to complete this section if the performing provider is different from the billing provider.

PA/DA COMPLETION INSTRUCTIONS

PAGE 1 — Complete all questions on Page 1 of the PA/DA for all dental or orthodontic PA requests.

PAGE 2 — For endodontic PA requests, complete questions 1, 2, 3, 4, 5, 6, 8.
For periodontic PA requests, complete questions 1, 2, 3, and 7.
For partial denture PA requests, complete questions 1, 2, 3, 8, and 9.

PAGE 3 — Complete all questions on Page 3 for partials and dentures.

Appendix 24
Wisconsin Medicaid Information Needed For Prior Authorization Requests

When completing prior authorization (PA) requests, please:

- Thoroughly answer all appropriate questions.
- Provide all the key information about the recipient's case.
- Give enough information for Wisconsin Medicaid dental consultants to make a reasonable judgment about the request. This is the only information they have on which to base their decision.

Careful completion of all necessary PA questions will:

- Decrease the number of resubmissions.
- Prevent denials due to inadequate information.

ADA PROCEDURE CODE	SERVICE	INFORMATION NEEDED
Preventive Services		
01351	Sealants	PA required for most teeth but not required for first and second permanent molars.
01515	Space maintainer	Two bitewing x-rays (PA required ages 13-20).
Restorative Services		
02932, 02933	Composite/prefabricated resin crown, prefabricated stainless steel crown with resin window	One periapical x-ray (PA required for adults over age 20 only).
W7126	Upgraded crown	One periapical x-ray.
Endodontic Services		
03310, 03320, 03330	Anterior, bicuspid, and molar root canal therapy	- One periapical x-ray. - Two bitewing x-rays. - Intraoral charting (PA/DRF Element 17). (PA always required for adults over age 20 on all teeth and for children on molar teeth.)
03410	Apicoectomy (anterior only)	- One periapical x-ray.
03430	Retrograde filling	- One periapical x-ray.
Periodontic Service		
04341	Periodontal scaling and root planing	- Periodontal charting.
04355	Full mouth debridement	- Periodontal charting. - Minimum of 4 bitewing x-rays or a full mouth x-ray.
04910	Periodontal maintenance	- Periodontal charting.

ADA PROCEDURE CODE	SERVICE	INFORMATION NEEDED
Prosthodontic Services		
05110-05120	Denture	- If replacing lost/stolen prosthesis, include official explanation of loss and a plan to prevent future loss.
05211-05212 W7127-W7128	Partial denture Upgraded partial denture	- X-rays sufficient to show entire arch plus bitewings, if appropriate. - Periodontal charting. - Intraoral charting (PA/DRF Element 17). - If replacing lost/stolen prosthesis, include official explanation of loss and a plan to prevent future loss.
05955	Palatal lift	- If replacing lost/stolen prosthesis, include official explanation of loss and a plan to prevent future loss. - Physician or speech pathologist statement documenting speech impediment.
Fixed Prosthodontic Services		
06545, 06940-06980 W7310-W7320	Fixed prosthodontics	- Periapical x-rays sufficient to show treatment area. - Periodontal charting of abutment teeth.
Oral and Maxillofacial Surgery Services		
07280-07281	Surgical exposure	- One periapical x-ray. - HealthCheck referral.
07530-07540 and equivalent CPT codes	Removal foreign body	- One periapical x-ray. (PA not required for POS 1 or in an emergency.)
07840-07860, 07950, 07991 07992 and equivalent CPT codes	TMJ surgery	- TMJ second surgical opinion. - Document non-surgical treatment. - Operative and post-op plan of care. - X-ray report.
07940, 07960 and equivalent CPT codes	Orthognathic surgery, frenulectomy	- HealthCheck.
Orthodontic Services		
08110-08750 W7910-W7920 00340	Orthodontic service	- HealthCheck referral. - Study models. Pack study models securely in packing material to prevent breakage.

All PA requests require:

- A statement from the dentist regarding the reasons for the requested treatment.
- Answers to all appropriate questions on all PA forms.
- Signatures and dates on each form.

When appropriate, include the following information:

- A description of the recipient's oral health.
- Any physical or mental disability that affects the recipient's dental health and hygiene.
- Any state/federal law that requires the recipient to receive treatment (such as when a child is in foster care).
- Any medical condition that affects the recipient's dental health.
- The relationship between the prior authorized treatment and other dental treatment in progress.
- Trauma situations that have affected the treatment needed.
- Efforts to date to correct the problem.
- Additional X-rays or intraoral pictures if they are needed to better document the situation.

Appendix 25
Provision of Upgraded Partial Denture and Crowns to Medicaid Recipients

A dentist/dental clinic must submit the following form or another written document with the same information upon submission of the first prior authorization (PA) request to provide an upgraded partial denture and/or crown (higher quality than currently covered by Medicaid) to a Medicaid recipient. All subsequent PA requests to provide an upgraded crown or partial denture *under the same dental clinic/dentist provider number* must either contain the same form or reference as the previously submitted document.

1. All Medicaid patients who receive services from the dentist/dental clinic listed below are eligible to receive upgraded crowns and/or partial dentures based on the following medical criteria established by the dental office:

2. All Medicaid recipients who receive upgraded crowns and/or partial dentures are charged no more than $3 copayment, unless the recipient is exempt from copayment charges as based on Medicaid copayment exemptions outlined in Part A, the all-provider handbook.

3. Medicaid payment along with the $3 recipient copayment is accepted as payment in full for the upgraded procedures.

Dentist/Dental Clinic (printed)_____

Dentist/Dental Clinic (signature)_____

Medicaid Provider Number _____ Date _____